MILITARY NURSES PERCEPTIONS OF AUTONOMY

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Military nurses sustain the health of deployed soldiers in a variety of contingencies. Autonomy is considered by nurses to affect both job satisfaction and the delivery of effective patient care. Previous studies showed that military nurses perceptions of autonomy, as well as most indicators of job satisfaction, were lower than their civilian counterparts. Yet, when deployed, military nurses must function with greater autonomy than most of their civilian counterparts. To develop autonomy and authority in the military nurse, their current perceptions of autonomy must be known. Based on the Power Theory, Kanters Model of Power and Opportunity and Organizational Empowerment Model, a comparative descriptive design was used to determine the perceived autonomy of military nurses both with and without deployment experience. Perceptions of autonomy and authority were only slightly above midpoint for the questionnaire scale, regardless of grouping by deployment experience, position held (rank) or work environment. Nurses with deployment experience had slightly higher perceptions of autonomy and authority. Type of work experience (unit) influenced perceptions of authority and autonomy.

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ABSTRACT

Military nurses sustain the health of deployed soldiers in a variety of contingencies. Autonomy is considered by nurses to affect both job satisfaction and the delivery of effective patient care. Previous studies showed that military nurses' perceptions of autonomy, as well as most indicators of job satisfaction, were lower than their civilian counterparts. Yet, when deployed, military nurses must function with greater autonomy than most of their civilian counterparts. To develop autonomy and authority in the military nurse, their current perceptions of autonomy must be known. Based on the Power Theory, Kanter's Model of Power and Opportunity and Organizational Empowerment Model, a comparative descriptive design was used to determine the perceived autonomy of military nurses both with and without deployment experience. Perceptions of autonomy and authority were only slightly above midpoint for the questionnaire scale, regardless of grouping by deployment experience, position held (rank) or work environment. Nurses with deployment experience had slightly higher perceptions of autonomy and authority. Type of work experience (unit) influenced perceptions of authority and autonomy.

Key Words: **autonomy authority military nurse deployment work environment**

MILITARY NURSES' PERCEPTIONS OF AUTONOMY

By

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PREFACE

This research was conducted to provide information on the affects of healthcare restructuring and readiness initiatives in the Army Nurse Corps. It was designed to support and further readiness training for future Army nurses.

DEDICATION AND/OR ACKNOWLEDGMENT

This work is dedicated to my husband and family, without whom I would not have made it through this extremely challenging time. To my committee members, especially Dr. Agazio, for your time, patience, understanding and baby-sitting. To my classmates, there will never be another class quite like ours. Your support and friendship made the tough times bearable. And to my friend Dave, you kept me sane and lifted my spirit.

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CHAPTER I: INTRODUCTION

Restructuring in the military, and the subsequent significant restructuring of the military healthcare system, has influenced all military healthcare professionals. Military nurses must adapt to the changing health care system, while providing quality patient care and maintaining a continued level of medical readiness for deployment. Medical readiness necessitates preparation for deployment during both wartime missions and operations other than war. Military nurses sustain the health of deployed soldiers in a variety of contingencies.

Long work hours, chronic staffing shortages, and task overload are stressors experienced in both civilian and military nursing. Assignment to isolated environments, lack of logistical support, decreased emotional support, continuous exposure to the severe trauma of war, and constant threat of personal danger are unique stressors in military nursing. The very nature of military deployment distinguishes the military nurse from nurses in the civilian sector (Kennedy, Hill, Adams and Jennings, 1996). Provision of healthcare in an austere environment, with limited logistical and collegial resources, demands a certain level of versatility and autonomy (Wijk, 1997).

Background

Autonomy is considered by nurses to affect both job satisfaction and the delivery of effective patient care. Robinson, Rodriguez, Sammons and Keim (1993) link autonomy not only to job satisfaction and perception of work environment, but also to nursing burnout. Increasing delegated authority to nurses delivering care increases the quality and decreases the cost of care, while increasing job satisfaction (Blanchfield & Biordi, 1996).

Wijk (1997) related work environment to job related stress and burnout in military nurses. The forty-six nurses studied were assigned to various fixed facilities ranging from large medical centers to small, isolated clinics. Upon completion of questionnaires determining the level of job stress and the presence of burnout, burnout rates were found to be 34% higher among registered nurses and senior ranking nurses. After interviewing a random sample of the respondent nurses, the increased burnout/stress was found to be due to the requirement that these nurses function more autonomously owing to a shortage of physicians. Graduate nurses initially assigned to isolated areas were unable to function autonomously in a military medical environment due to a lack of acquired competence.

The demands placed upon nurses during times of war are not well documented. Beeber (1996) related the consequences of the mass deployment of nurses during World War I with the initial growth of autonomy in the nursing profession. Removed from the clean, physician-directed hospital and thrust into the trenches of the battlefield, nurses were required to act autonomously for the good of the patient. Nurses were confronted by massive, traumatic wounds and an often-overwhelming number of patients. Plagued with limited resources and few physicians, nurses abandoned obedience and assumed autonomy in judgment. Upon return home, these nurses no longer saw themselves as 'nurse-handmaids', but as collaborators with physicians.

Using a phenomenological approach, Scannel-Desch(2000), found that the experiences of nurses during the Vietnam War were ones of emotional hardship. Caring for very young, disfigured soldiers, having to return less severely wounded soldiers to combat and the constant threat of the enemy were significant stressors to the military nurses interviewed. Mass casualty situations in which the triage principle of "the greatest good for the greatest number" were frequent and nurses were often used as the triage officers. Such situations required autonomy and independent judgment based on education and clinical experience (Scannel-Desch, 2000).

Significance

Many lessons learned from previous deployments are currently being used to promote overall readiness among today's military nurses. Military nurses learn flexibility through a variety of duty assignments and duty positions. Proficiency in a wide range of roles and responsibilities should assist the nurse in developing autonomy in the delivery of patient care in any contingency. The current conceptual model of Army nursing practice describes 'cure' as the independent and dependent nursing measure used in a coordinated process of patient care delivery (Kennedy et al., 1996). Creating empowering fixed facility environments which produce autonomous practitioners able to function in adverse environments ultimately benefits not only the patient but also the mission of military nursing: conserving the fighting strength.

Statement of the Problem

When compared to civilian nurses, military nurses have perceived themselves as having little autonomy (Robinson et al., 1993; Wijk, 1997; Alpass, Long, Chamberlain and MacDonald, 1997). Yet, when deployed, military nurses must function with greater autonomy than most of their civilian counterparts. Military nurses have limited opportunity for involvement in decision making and innovation in regard to patient care decisions. The hierarchical nature of the military rank

structure tends toward the rigid and therefore, may stifle autonomy. Staff nurses initially entering the military attain the lowest officer rank and thus have restricted decision making authority and limited autonomy. The effect of the current environment and continued restructuring of the military healthcare system on the attainment of autonomy by initial entry nurses is unclear but warrants further study. The goal of military nursing must be to develop analytical, flexible, resourceful and accountable practitioners in order to attain optimal military medical readiness (Valimaki et al., 1999).

Research Questions

Two studies (Maloney, Anderson, Gladd, Brown, and Hardy, 1996; Robinson et al., 1993) have researched the question of whether being in the military affected nurses' perceptions of work life and job satisfaction. The results of the studies showed that military nurses' perceptions of autonomy, as well as most indicators of job satisfaction, were lower than their civilian counterparts. The studies were limited, in that the military nurses were assigned to fixed facilities, with only one facility in a foreign country. Neither study addressed the issue of deployment and its affects on perceptions of autonomy.

Research is needed to assess the effects of the massive restructuring of the military health care system on the current perceptions of autonomy held by military nurses with and without

deployment experience. In order to develop autonomy and authority in the military nurse, their perceptions of autonomy must be known. The purpose of this study is to address the following questions:

1. What are military nurses' perceptions of autonomy?
2. Are the perceptions of autonomy different between nurses that have been deployed versus those who have no deployment experience?
3. Do the perceptions differ based upon rank/position?
4. Do the perceptions of autonomy differ based upon work unit?
5. Is there a difference in perceptions of work environment characteristics between nurses that have been in a deployed environment versus those who have not been deployed?
6. Is there a relationship between perceptions of work environment and perceptions of autonomy for nurses that have been in a deployed environment?
7. Is there a relationship between perceptions of work environment and perceptions of autonomy for nurses who have never deployed?

Conceptual/Theoretical Framework

The main concepts and assertions of the Power Theory provide the conceptual framework for this study. Power is the means by which individuals affect organizational outcomes by use of authority (legitimate delegated power) and autonomy (expert

power). Power can be gained from five bases: coercive, legitimate, reward, referent and expert. The basis of authority and autonomy in nursing are legitimate and expert power (Blanchfield and Biordi, 1996). Delegated authority allows the nurse to make patient care decisions within their defined role, whereas, autonomy allows the nurse to independently implement the decisions/responsibilities based on acquired knowledge and experience (Leddy, and Pepper, 1998).

Additionally, Kanter's Model of Power and Opportunity describes the importance of creating a work environment that fosters professional practice within an organization. The model theorizes that the relationship between power, autonomy and accountability is dependent on opportunity for implementation and therefore directly related to job satisfaction (Upenieks, 2000).

The Organizational Empowerment Model describes the means by which structural factors such as access to logistical and supervisory support, information, and opportunity have a major influence on an employee's ability to accomplish work. With a decrease in management due to restructuring, an increased span of control is passed to the lowest levels. Staff nurses must therefore be competent, empowered, accountable and supported by the organization. Individuals with opportunities to grow and learn within their work settings are empowered and able to

accomplish the organizational mission (Laschinger and Wong, 1999).

Conceptual/Operational Definitions

Autonomy - Theoretically, autonomy is defined as the ability to exercise considered, independent judgment based on knowledge and independently carry out responsibilities of position without close supervision (Blanchfield & Biordi, 1996).

Operationally, autonomy was measured by the Nursing Authority and Autonomy Scale.

Authority – Theoretically, authority is defined as the ability to make decisions and perform role-related functions (Blanchfield & Biordi, 1996).

Operationally, authority was measured by the Nursing Authority and Autonomy Scale.

Collaboration – Collaboration involves the potential for equally valued contributions by all healthcare providers.

Deployed facility – A deployed facility is a non-permanent, movable, often austere facility used to deliver medical care during times of military mobilization. Deployed facilities utilize minimal technology and manual equipment.

Empowerment – Empowerment is defined as being able, and having, the ability to choose. Empowerment requires critical introspection and a subsequent change in behavior.

Fixed facility – A Fixed facility is a permanent structure for the delivery of healthcare. Fixed facilities utilize a high degree of technology and automation.

Job satisfaction – Theoretically, job satisfaction is defined as the degree of positive affective orientation towards the job. Operationally, job satisfaction will be assessed by the Needs Satisfaction Questionnaire (Blanchfield & Biordi, 1996; Byers et al., 1999; Maloney et al., 1996; Porter, 1961; Robinson et al., 1993; Upenieks, 2000; Wijk, 1997).

Operations other than war – are defined as mobilization of military forces for the purpose of training, peacekeeping or disaster relief.

Readiness – is defined as a state of preparedness for anticipated deployment.

Work environment – Theoretically, work environment is defined as the internal and external factors influencing individuals and their performance.

Operationally, work environment will be measured by the Needs Satisfaction Questionnaire (Blanchfield & Biordi, 1996; Byers et al., 1999; Maloney et al., 1996; Porter, 1961; Robinson et al., 1993; Upenieks, 2000; Wijk, 1997).

Work Experience – Theoretically, work experience is defined as the clinical and leadership experience acquired by performing various roles and responsibilities in a variety of settings.

Operationally, work experience will be determined by the demographic data questionnaire.

Limitations and Assumptions

A major limitation of the study is the small number of presently deployed nurses available for the study, which could affect the generalizability of the information. Information obtained from previously deployed nurses may be affected by memory and experiences after deployment.

Assumptions made for the purpose of this research were:

1. Nursing in the deployed environment necessitates a level of autonomy in the provision of quality patient care.
2. The multitude of changes occurring during the restructuring of military healthcare is affecting the execution of expanded roles and perhaps previous perceptions of autonomy.
3. Respondents will answer honestly.

CHAPTER II: REVIEW OF THE LITERATURE

History

The progression of professional nursing toward autonomy in clinical practice has been aided by the contributions of military nurses, beginning with the volunteer nurses of the Revolutionary and Civil Wars. As self-employed private duty nurses, nurses prior to 1930 experienced autonomy in practice. With the emergence of institutionalized nursing, autonomy gave way to regimentation, labor divisions and strict supervision (Aydelotte, 1982). With each new military deployment, nurses experienced daunting conditions while providing care to the injured (Higgins, 1996).

Common themes are found when reviewing the experiences of military nurses, regardless of the deployment. Themes including personal reactions to the war experience, living in the military, nursing in the military and the images and sensations of war, are related by all military nursing veterans having experienced combat. Feelings of unrelenting mental and physical fatigue, grief, fear, courage and productivity are echoed as characterizing the experiences of war (Stanton, Dittmar, Jezewski and Dickerson, 1996).

The physical hardships of living in the military and maintaining the basic needs of hygiene, food, and shelter have

been compounded by confusion and fear due to possible attack. Crude, undersupplied and under staffed hospitals have increased the emotional impact of caring for horribly wounded soldiers (Stanton et al., 1996).

Multiple studies have shown that younger and more novice nurses have been unprepared for the carnage and personal dangers thrust upon them in wartime. This often has led to an inability to function in situations of stress. Nurses who have been able to adjust to the stresses placed upon them became accustomed to making decisions, improvising, and taking the initiative in problem solving in the provision of patient care. Autonomous practice was not desired, but was necessary for the delivery of care to severely injured soldiers (Kennedy et al., 1996; Scannel-Desch, 2000; Stanton et al., 1996; Wijk, 1997; Zadinsky, 1996).

Current military missions around the world involve the deployment of thousands of soldiers, airmen and sailors. The maintenance and conservation of the fighting force falls squarely on the shoulders of military medical and nursing personnel. Effective delivery of nursing care in a deployed environment requires preparation of all nurses to function autonomously in the delivery of patient care and is impossible without individual and unit readiness (Reineck, 1999).

Readiness

Readiness is defined as a state of preparedness for an expected experience or situation (Bester, 2000). The Department of Defense defines health care readiness as the "ability to mobilize, deploy and sustain field medical services and support for any operation requiring military services, to maintain and project the continuum of health care resources required to provide for the health of the force; and to operate in conjunction with beneficiary health care"(Bester, 2000, p.2).

With the continued deployment of military troops for humanitarian and conflict missions, military nurses are increasingly practicing in deployed environments. Zadinsky (1996) maintains that initial nursing skills and competencies are developed and sustained at fixed facilities. Furthermore, during deployment, the lack of a technologically automated environment forces nurses to utilize skills rarely used in fixed facilities. Deployment changes the nurse specialist (postpartum, pediatrics, orthopedics) into a nurse generalist. All nurses, regardless of specialized training, are considered medical-surgical nurses when deployed. Role adaptation is complicated by other environmental factors such as difficult living conditions, lack of logistical support, and danger (Bester, 2000; Kennedy, 1996; Zadinsky, 1996).

From 90 oral history interviews, a major need for flexibility and innovation among deployed nurses was identified as essential to the delivery of quality patient care and job satisfaction (Scannel-Desch, 2000). The nursing skills required, potential stress reactions, and ability to withstand the physical and emotional demands of deployment must be identified and developed while in a fixed facility. According to Reineck (1999), six interrelated components of readiness have been identified. They are: 1) clinical nursing competency, 2) operational competency, 3) survival skills, 4) personal/ psychosocial/physical readiness, 5) leadership and administrative support and 6) group identification. Clinical nursing competency includes the ability to utilize field equipment in the exercise of nursing skills, technical proficiency with field equipment, physical assessment skills, clinical decision-making aptitude and trauma/triage skills. The military nurse must perform skillfully and autonomously in missions ranging from low-scale conflict to full-scale war.

Training for a variety of environments, structures, equipment, roles and tasks (i.e., Nuclear Biological Chemical (NBC) decontamination) is critical to individual readiness. The Army Nurse Corps has identified three levels of readiness that must be attained in order to accomplish the mission. These levels include: 1) individual readiness, 2) sectional training,

and 3) collective training. The resources necessary for training are not always available to allow for extensive field training for every military nurse, therefore the ability to meet the various training needs required for successful deployment must be achieved in other ways (Bester, 2000).

Autonomy and Authority

Blanchfield and Biordi (1996) viewed health care restructuring as a means of increasing the nursing practice power base via empowerment through a change in role. The expanding roles of nurses at all levels of healthcare provision brings the potential of increased decision-making and autonomy by a redistribution of the current power base between medicine and nursing (Du Plat-Jones, 1999).

Several studies relate both the importance of decision-making to autonomous nursing practice and increased quality of patient care when decision making occurs at the point of care (the staff nurse)(Cullen, 2000; Fullam et al, 1998; Fulton, 1997; Kennerly, 2000; Roper and Russell, 1997). The processes of decision-making and implementation, which are the means of empowerment, necessitate the use of autonomy and authority.

Autonomy and authority can be differentiated by considering authority as the legitimate power of an individual within an organization and autonomy as the individual’s ability to independently perform his or her role/responsibilities within

the organization. Therefore, authority is necessary to make decisions but autonomy is needed to implement decisions. And, professional expertise acquires decision-making authority and the right to work autonomously (Blanchfield and Biordi, 1996).

Several studies indicate that an environment that supports autonomous nursing practice, by shifting decision making to the operational level, is directly related to increased perceptions of autonomy, job satisfaction, and ultimately retention (Allgood, et al., 2000; Dearmun, 1998; Collins et al., 2000; Aiken and Patrician, 2000; Mills and Blaesing, 2000; Sleutel, 2000; Upenieks, 2000; Prothero, Marshall and Fosbinder, 1999; Acorn, Ratner and Crawford, 1997).

Using the Nursing Authority and Autonomy Scale, a three part instrument, measuring: 1) nurses' perceptions of staff nurses' authority and autonomy, 2) nurses' perceptions of the importance of staff nurses' authority and autonomy, and 3) demographic information, a Pearson correlation coefficient demonstrated significant relationships among these variables.

Validity and reliability of the instrument was high. Reliability for the NAAS was indicated by a Cronbach's alpha of .86 for authority items, a .72 for autonomy items, a .84 for importance of authority items, and a .78 for importance of autonomy items.

Significant differences were found between the staff nurses' higher perception of their autonomy to enact patient care and authority ($p=.001$), and the nurse leaders' perception of the staff nurses' autonomy and authority. The interaction between the type of position the nurse held and the shift he/she worked, on perceived importance of autonomy was statistically significant ($F(2,583)=4.53$, $p=.011$). Night shift nurse leaders gave a higher importance to the autonomy and authority of night shift staff nurses than did day or evening shift nurse leaders ($p=0.5$). Furthermore, decreased size of the unit and hospital, which related to decreased number of layers between staff and management, correlated with increased perceptions of autonomy and authority in staff nurses and increased efficiency of care provided ($p=0.02$).

Alpass, and collegues, (1997) examined differences in job satisfaction between 571 military and 171 ex-military personnel. They noted higher leader support, lower job pressure, higher challenge, autonomy, and job importance, as factors related to higher levels of job satisfaction for the ex-military participants ($t(199.65)=5.97$, $p<.001$).

Military service influences an individual both within and outside the work environment. The expectation of selfless service 24 hours a day, 7 days a week, 365 days a year is a core

value of military service, and thus military nursing. Nowhere is this more true than in the deployment scenario.

Leadership's Role

Comparing military and civilian hospitals, Robinson et al., (1993) used the Work Environment Scale to measure issues of supervisory support and control, autonomy/self sufficiency and innovation, and a two-question assessment of morale. The sample consisted of 37 military nurses demographically matched with 37 civilian nurses (drawn from a pool of 314 civilian nurses). Multivariate analyses of variance showed that civilian nurses perceived greater supervisory support ($P<0.0001$), greater decision-making involvement ($P<0.001$), greater autonomy ($P<0.002$) and more opportunity to be innovative ($P<0.006$) than military nurses. These differences are believed to be directly related to the rigid structure and multi-layered management of the military setting. This added hierarchy (rank structure) was positive in relation to pay and benefits for military nurses. It was detrimental in that the military nurses felt less autonomous with respect to patient care decisions and felt little or no authority or ability to be innovative in the implementation of care. They reported they were stifled by the system.

A recent study by O'Rourke (2000), found many of the same findings concerning 201 Army nurses' perception of autonomy and

job satisfaction. Again, the need for supervisory support and communication were identified as requisites for development of an empowering environment that lead to development of staff autonomy.

Military nurses practice in an environment fraught with the continuous physical and emotional demands of crisis situations requiring critical decision-making responsibilities. Rapidly changing levels of responsibility, without proper preparation to act autonomously, or supervisory leadership/support decreases job satisfaction and predisposes the deployed nurse to burnout (Wijk, 1997).

Development of Autonomy

Byers and co-investigators, (1999), in comparing job satisfaction in military primary care clinics, found that 19 nurse practitioners at nine different clinics, were most dissatisfied with organizational policies, time pressures, and work setting issues. On the other hand, they were most satisfied with helping people, implementing direct patient care, providing quality care, and having independence in clinical matters. Autonomy and collaboration, which together accounted for one-third of the variance, were significant predictors of job satisfaction among these primary care providers.

Decreasing stress, a precursor to dissatisfaction and burnout, can be accomplished by interventions that address lack

of knowledge concerning nursing role and practice level. By addressing the environmental sources of stress: 1) training, 2) understanding individual roles and unit mission, 3) coworker support and 4) supervisory/command support, adjustment into the unit and an increased ability to cope is facilitated (Taormina, 2000).

Summary

The link between autonomy, job satisfaction and delivery of quality of patient care in a deployed environment is evident. Restructuring that reduces the primary care givers autonomy in patient care delivery, or that increases the levels of managerial control, decreases the care givers' authority to implement patient care. Subsequently this leads to decreased job satisfaction and eventually a decline in the quality and efficiency of patient care delivered. The military system tends toward centralized, formal management of patient care delivery and those who make decisions are most out of touch with direct patient care. This rigid, sometimes stifling system does not allow for the development of young, entry-level nurses into autonomous practitioners able to function optimally in a deployed facility.

Training received during initial assignments in fixed facilities must be such that critical-thinking, experience and acquired knowledge are used as a basis for the autonomous

delivery of patient care. The empowerment of nurses at the lowest level must begin in a supervised fixed facility and be able to translate smoothly to the deployed facility. Only in this way will military nurses obtain true readiness, increased job satisfaction and decreased burnout.

Although there is a wealth of research concerning the relationship between the nurses' perceptions of autonomy and job satisfaction, there is little information available concerning perceptions of autonomy among military nurses. Two research articles addressed job satisfaction among military nurses; however, these studies were performed in fixed facilities and did not specifically address the affects of deployment on nurses' perceptions of autonomy.

Only one study was found that compared military and civilian nurses' perceptions of autonomy, and then only in relation to job satisfaction. This study was neither recent nor did it reflect recent changes in the military healthcare system or the increase in deployments. With the increase in deployments, the need for nurses prepared to function autonomously in the harshest conditions, at a moment's notice is essential to the delivery of military healthcare. The first step therefore, is to determine the military nurses' current perceptions of their autonomy in practice based on deployment experience. This information will be instrumental in designing

training programs to assist future military nurses preparing for deployment.

CHAPTER 3: Methodology

Introduction

The purpose of this study was two fold: first, to describe nurses' perceptions of autonomy based on deployment experience and second, to determine if they differ based upon rank and experience.

A comparative descriptive design was used to determine the perceived autonomy of military nurses both with and without deployment experience.

Methods

Sample Groups

A convenience sample of approximately 200 Army nurses from the Walter Reed Army Medical Center was invited to participate in the study. The target group included registered nurses of all ranks assigned to medical-surgical units, intensive care units and emergency departments. The site chosen enabled data collection from a broad sample of nurses with varied nursing experience levels and deployment experience. Controlling the probability of a type I error at alpha=0.05, a sample of 96 per group (fixed facility and deployment experience, total 192) had 80% power to detect at least a 28% difference in perceptions of autonomy. To allow for dropouts and incomplete questionnaires, up to 120 subjects per group were recruited (Kraemer and Thiemann, 1987).

Instruments

Two questionnaires, the Nursing Authority and Autonomy Scale (NAAS), and the Needs Satisfaction Questionnaire (NSQ) were employed.

The NAAS, a three-part instrument developed by Blanchfield and Biordi (1996), is based on Katzman's (1989) Authority in Nursing Roles Instrument and the Stamps and Piedmonte Job Satisfaction Index. The first section of the NAAS consists of 28 items measured nurses' perceptions of staff nurses' authority and autonomy. The second section consists of 10 items measured nurses' perceptions of the importance of staff nurses' authority and autonomy. The third section consisted of demographic items.

Reliability for the NAAS was indicated by a Cronbach's alpha of .86 for authority items, a .72 for autonomy items, a .84 for importance of authority items, and a .78 for importance of autonomy items. Expert reviews and several pilot studies were used to establish the content validity of the NAAS (Blanchfield & Biordi, 1996). An alpha of .84 was obtained for internal consistency of autonomy/authority items and .85 for importance of autonomy/authority items in this study.

The NSQ, based on Maslow's theory, measured a person's perceived deficiencies in several areas. The areas covered include: 1) security, 2) social, 3) esteem, 4) autonomy, and 5)

self-actualization. Two responses are obtained for each item and the need deficiency calculated. Test-retest reliability has yielded Cronbach alphas ranging from .45 to .67 (Hall & Mansfield, 1975). In this study, an internal consistency alpha of .89 and .91 was obtained for reliability

Human Subjects

Before initiation of data collection, Institutional Review Board (IRB) approval was obtained from both the Uniformed Services University and the IRB of the facility participating in the research. Participation in the study was strictly voluntary and all demographic information obtained was kept confidential. A letter of explanation and a request for participation accompanied each questionnaire, along with a stamped return envelope. The participant completing and returning the questionnaire implied consent, therefore no other consent form was required.

Procedures

The PI distributed questionnaire packets to the individual mailboxes of participants at the facility. Questionnaires were distributed with a stamped, return envelope to enhance individual return rates. Distribution of the questionnaire was followed by an e-mail reminder (mass mailing to all nurses) at 45 days post distribution and a letter of appreciation for participation sent to the facility chief nurse, upon completion

of the data collection. A pilot study was conducted to establish the length of time needed to complete all questionnaires and discern any possible difficulties with instrument completion. Five Graduate School of Nursing students (three with deployment and two without deployment experience) participated in the pilot study. Data collection began in March 2002.

Analysis

Descriptive (crosstabs) and inferential statistics were used to test differences between staff nurses based upon demographic information. Cronbach's alpha was used to re-verify reliabilities of the instruments with this sample (as reported above). A two-group independent t-test was performed for the variables of authority, autonomy, importance of authority and importance of autonomy based on deployment experience. Additionally, a two-group independent t-test was utilized to discern differences in perception of work environment characteristics between those with deployment and those without deployment experience.

Two-way analysis of variance (ANOVA) were conducted to test for potential differences among groups based on rank/position (group variables). Pearson correlation coefficients were used to test significant relationships between work experience as well as relationships between perceptions of work environment

and perceptions of autonomy. The SPSS program v.10.1 was used for entry and organization of data.

CHAPTER IV: DATA ANALYSIS

Introduction

With the increase in deployments, the need for nurses prepared to function autonomously in the delivery of military healthcare is essential. The first step therefore, is to determine the military nurses' current perceptions of their autonomy in practice.

Sample Characteristics

Active duty nurses comprised the 60 respondents (37.5% return) in the sample group. All respondents met the inclusion criteria of being active duty Army Nurse corps officers working in non-critical care (Med-surgical, pediatrics, etc.) or critical care areas (ICU, OR, ED). The sample was almost equally split between males and females at 51.7% and 48.3% respectively. The ages of the sample group ranged from early twenties to mid fifties with the majority of respondents (43.3%) being in the 19-29 age group, followed by the 30-39 age group (31.7%), 40-49 age group (16.7%) and the 50-59 age group (8.3%).

Ninety percent of respondents had a baccalaureate degree as their initial nursing education followed by associate degree (8.3%) and diploma (1.7%). The highest education level obtained ranged from baccalaureate to doctorate degree. Forty-four, (73.3%) reported a baccalaureate degree as the highest education obtained, 15 (25%), reported Masters degree (not all in nursing)

and 1 (1.7%) listed the Doctorate as the highest degree attained.

The majority of respondents (33.3%) had only one to two years of nursing experience. Sixteen percent (16.7%) had 3-5 years experience, 18.3% had 6-10 years experience, 13.3% 11-15 years and 6.7% for both 16-20 years and greater than 20 years experience. Twenty-seven or 45% were currently in the position of staff nurse, 17 or 28.3% were charge nurses, four or 6.7% were assistant nurse managers, 10 or 16.7% were nurse managers and two or 3.3% identified themselves as advanced practice nurses. Fifty-seven percent (56.7%) of respondents replied that they had been in their current position for one year or less, followed by 41.7% who had been in their current position 2-5 years and 1.7% at 6-10 years.

Thirty-one or 51.7% of respondents worked rotating days, while 30% worked permanent days, 1.7% evenings and 16.7% nights. The majority (58.3%) of respondents listed non-critical care areas as the type of unit worked, while 41.7% listed critical care areas. Forty percent of respondents reported being certified in their specialty area. Of the sixty respondents, 40 (66.7%) had never been deployed, 13 (21.7%) had been deployed once and 7 (11.6%) had been deployed two or more times. Of these, 46.7% felt prepared for deployment while 25% did not, and the remainder did not answer the question.

Research Question One

What are military nurses' perceptions of autonomy?

Nurses who have been deployed are expected to perform duties in austere and stressful environments, with little or no supervision and therefore must be prepared to make critical autonomous decisions in patient care.

To determine perceptions of autonomy, the respondents were asked to complete the Nursing Authority and Autonomy questionnaires, the first assessing their current perceptions of their own authority/autonomy and the second assessing the importance they place on authority/ autonomy in the performance of their work. The first questionnaire had a possible total score of 140 (100 points for authority items and 40 points for autonomy items) using a Likert-type scale ranging from 5=strongly agree to 1=strongly disagree. The second questionnaire had a total possible score of 50 using the same Likert-type scale. The Overall mean for the perception of staff nurses' authority and autonomy for the group was 94.8 representing a range from 42 to 120 (SD 16) out of a possible 140 points. The mean scores for belief in the importance of staff nurses' authority and autonomy was 43.6 with a range of 30-80 and a standard deviation of 6.96. Table 1 summarizes the overall scores for both questionnaires.

Table 1.

Perception of Autonomy Scores

	Minimum	Maximum	Mean	Std. Deviation	Cronbach's reliability
28 Item Autonomy/Authority Questionnaire	42.00	120.00	94.8	16.03	.84
10 Item Importance of Autonomy/Authority	30.00	50.00	43.6	6.96	.85

N=60

Research Question Two

Are the perceptions of autonomy different between nurses that have been deployed versus those who have no deployment experience?

When compared by deployment experience, the mean score for the nurses without deployment experience was slightly lower than those nurses with deployment experience on the autonomy/authority questionnaire. Whereas, the mean for the importance of autonomy/authority was slightly higher for non-deployed nurses compared to those with deployment experience.

Table 2.

Perceptions of Autonomy by Deployment Experience

	N	Autonomy/Authority Questionnaire	Importance of Autonomy/Authority
Deployed	20	98.40	42.20
Non-deployed	40	93.22	44.35

Independent T tests were performed between both scores to detect differences in perceptions between the groups based on deployment experience with no significance found. No significant differences were found based on the demographics of the two groups on the perceptions of authority/autonomy scale.

Research Question Three

Do the perceptions differ based upon rank/position?

The military system's centralized, formal management of patient care and rigid rank system (more rank equals more responsibility) implies that the more rank or higher position of authority achieved, the more autonomous the practice.

The score for nurse managers was lower, at 90.43, than those of either the staff nurses (93.85) or charge nurses (100.47) for perceptions of autonomy/authority, as were their belief in the importance of autonomy/ authority at 42.43 versus 44.92 for staff nurses and 42.70 for charge nurses. However, because the questionnaire was worded to illicit staff nurses'

perceptions, it is unclear from what perspective the nurse managers answered, i.e., their own autonomy or the autonomy of the staff nurses working for them. Due to the possible measurement inaccuracy owing to the instrument wording, no significance testing was performed and this question was unable to be answered.

Research Question Four

Do the perceptions of autonomy differ based upon work unit?

Nurses working in critical care areas such as the emergency department (ED), operating room (OR) and intensive care unit (ICU) are expected by virtue of advanced education and experience to function in a stressful environment and base decisions on critical thinking. However, as seen in Table 3, the nurses working in critical care areas received a score of 92.69 for the perceptions of autonomy versus 96.44 for nurses working in non-critical care areas. The importance of autonomy/authority was equal between the groups. Independent t-tests were non-significant.

Table 3.

Perceptions of Autonomy/Authority by Work Area

	N	Autonomy/Authority Questionnaire	Importance of Autonomy/Authority
Critical Care	26	92.69	43.08
Non-Critical Care	34	96.44	43.5

Research Question Five

Is there a difference in perceptions of work environment characteristics between nurses that have been in a deployed environment versus those who have not been deployed?

Work environment and job satisfaction are essential in the delivery of quality patient care. In order to assess work environment, the respondents were asked twelve questions concerning their current work environment. Questions covered items such as 1) opportunity to help others, 2) availability of mentorship, 3) self-esteem, 4) authority and autonomy, and 5) self-fulfillment and security. Each question asked how the respondent currently perceived each area and additionally, how the respondent felt each area "should be". A Likert-type scale of 7=maximum and 1=minimal was used and deficits for each area were calculated. Table 4 illustrates the overall group scores for the questionnaire.

Table 4.

Perceptions of Work Environment Based on Deployment Experience

	Deployment Experience	N	Mean	Std. Deviation
Questions asking: How much is there now?	Yes	20	60.95	16.98
	No	40	59.50	12.32
Questions asking: How much should there be?	Yes	20	76.80	6.42
	No	40	76.02	7.74
Difference or perceived deficit	Yes	20	15.95	13.80
	No	40	16.62	12.71

No significant difference was found between in the relationship between perceptions of autonomy and work environment based upon deployment experience.

Research Question Six

Is there a relationship between characteristics of the work environment and perceptions of autonomy for nurses that have been in a deployed environment?

Using Pearson Correlation coefficient, no significant relationship was found between characteristics of the work environment and perceptions of authority and autonomy based on deployment experience (Table 5).

Table 5.

Correlations Between Perceptions of Autonomy and Work Environment for Nurses with Deployment Experience

Correlations

		Total of how work is now	Total for how work should be?	Total for the difference how much work is and how work should be
Total of authority/ autonomy scale	Pearson Correlation	.201	.150	-.185
	Sig. (2-tailed)	.395	.528	.436
	N	20	20	20
Total score for importance of authority /autonomy scale	Pearson Correlation	.392	.388	-.297
	Sig. (2-tailed)	.088	.091	.203
	N	20	20	20

Research Question Seven

Is there a relationship between characteristics of the work environment and perceptions of autonomy for nurses who have never been deployed?

Nurses without deployment experience, working in critical care areas, perceptions of their work environment had a mean of 54.41, while non-critical care nurses had a mean of 63.26. Perceptions of how their work environment (should be) were higher for critical care nurses (0=77.23) than for their non-

critical care counterparts (0=75.13). No significant correlations were found between work environment and perceptions of autonomy in nurses without deployment experience (See Table 6).

Table 6.

Correlation Table for Autonomy/Authority and Work Environment for Non-Deployed Nurses

Correlations

		Total of how work is now	Total for how work should be?	Total for the difference how work is and work should be
Total of authority and autonomy scale	Pearson Correlation	.206	.191	-.075
	Sig. (2-tailed)	.202	.237	.644
	N	40	40	40
Total score for importance of authority /autonomy scale	Pearson Correlation	-.003	.196	.126
	Sig. (2-tailed)	.987	.225	.438
	N	40	40	40

Summary

This chapter presented the compilation of data collected from questionnaires completed by 60 Army Nurse Corps officers at Walter Reed Army medical center. The intent was to discern the perceptions of autonomy for this unique population in relation to deployment experience and work environment.

CHAPTER V: SUMMARY: CONCLUSIONS AND RECOMMENDATIONS

Introduction

The mission of the Army Nurse Corps is to provide nursing leadership and quality nursing care, in both peacetime and contingency operations, in support of the mission of the Army Medical Department (AMEDD)and the United States Army. As stated in the Army Nurse Corps Professional Development and Readiness Guide (2000), the vision of the Nurse is to create:

"A devoted team, highly competent and knowledgeable in core nursing skills, dedicated to be the premier nursing organization in our country, providing leadership to the Army Medical Department and professional and compassionate care to our army families, both at home and abroad."(p.7)

In order to achieve this vision, the Army Nurse Corps has set forth five goals. These goals focus on 1) maintaining core competencies, 2) collaborative decision-making, 3) valuing each other, 4) mentoring and 5) communication. Despite the implementation of this vision and these goals, which would seem to foster the development of autonomy at every level of nursing within the corps, Army nurses' perceptions of their autonomy in practice is lacking. The purpose of this study was to determine military nurses' perceptions of autonomy and whether these perceptions are influenced by deployment experience, rank or position and work environment.

A comparative descriptive design was used to discern the perceived autonomy of military nurses with and without deployment experience and to further discern influences of rank/position and work environment. Perceptions of autonomy were identified through the use of the Nursing Authority and Autonomy Questionnaire and work environment influences through the use of the Needs Satisfaction Questionnaire. Chapter V presents a summary of the research findings and conclusions, implications and recommendations for further research and limitations to the study.

Discussion of Findings

Overall, perceptions of autonomy and authority were only slightly above midpoint for the questionnaire scale, regardless of grouping by deployment experience, position held (rank) or work environment. However, nurses with deployment experience did have slightly higher perceptions of autonomy and authority.

Military command structure may limit decision making power and innovative opportunities for those of lower rank (staff nurses)(Robinson et al. 1993). The majority of respondents (73%) in this study were staff or charge nurses. Twenty respondents (33.3%) had less than two years nursing experience, ten (16.7% had less than five years experience and twelve (twenty percent) had less than ten years experience. Staff nurses comprised 45% of the respondents, while 28.3% claimed

charge nurse as their position; the rest were considered nurse managers.

Interestingly, while all three groups held authority/ autonomy as having high importance, perceptions of autonomy were lowest for the nurse managers, when compared to the staff nurses and highest for charge nurses. This could be due to the fact that all respondents completed the same questionnaire, which was worded more towards the staff nurse perspective and it is unclear from what perspective the nurse managers answered these questions. Delegation of authority to the charge nurse implies increased ability for decision-making and independent implementation in delivery of care (Leddy and Pepper, 1998).

Type of work experience (unit) influenced perceptions of authority and autonomy. Unlike previous studies (Blanchfield and Biordi, 1996), little difference in perception was seen between nurses working in the critical care areas as opposed to non-critical areas. This could possibly be attributed to the uniqueness of military nursing and training or the intermingling of deployed nurses throughout the units. Changes within the military healthcare system have resulted in fewer specialty (i.e., ICU, OR, etc) trained nurses. Consequently, nurses working in non-critical areas are required to care for more complex patients.

Military nurses, regardless of deployment experience reported an approximately 20 point deficit in perceptions of how their work environment "was now" and perceptions of "how they felt it should be", in areas such as autonomy, self-esteem, mentorship and opportunities for growth. When compared to the Army Nurse Corps goals, improvement is needed in the areas of 1) collaborative decision-making, 2) valuing each other, 3) mentoring and 4) communication. Kanter's Model of Power and Opportunity puts forth the importance not only of power, autonomy and accountability in practice but the necessity of creating a work environment that fosters the opportunity for their implementation (Upenieks, 2000).

No relationship was found between characteristics of the work environment and perceptions of autonomy for nurses that have been in a deployed environment. In fact, the deployed nurses working in critical care areas reported less deficit in perceptions of their work environment than did critical care nurses without deployment experience. However, nurses in the non-critical care areas without deployment had higher perception of their current work environment than did those who had been deployed. Younger, less experienced nurses had a more idealistic view of what "work environment should be like". Differences in deployment experience and perception of work environment can be related to the importance of empowerment

through environment: the smaller the hospital, the more interactive the management. Most deployed facilities are fewer than 200 beds (mission dependent) and staffed by fewer than 100 nurses. Another possibility is that once a nurse has been deployed, anywhere else is tolerable.

Conclusions

This study has provided an opportunity to add to the limited published research concerning military nurses. The population was described in relation to perceptions of authority and autonomy based on deployment experience and work environment. The military nurses in this sample group did not significantly differ in perceptions of authority and autonomy based upon previous deployment experience. These perceptions were not significantly influenced by type of unit or position. There was no relationship between perceptions of work environment and autonomy for nurses with or without deployment experience.

Implications

The findings have implications for nursing readiness and retention and support the need for further research. Continued restructuring in the military healthcare system, coupled with increasing deployments, necessitates that the Army Nurse Corps move toward attainment of the five leadership goals. These goals, set forth to ensure readiness, are directly related to

the authority and autonomy perceived by nurse corps officers at every level, by providing an empowering environment and opportunity for implementation of autonomy (Laschinger and Wong, 1999; Upenieks, 2000).

Perception of autonomy and/or lack thereof has been linked to job satisfaction and delivery of patient care (Reineck, 1999; Robinson et al., 1993). Specific factors influencing perceptions of autonomy and authority must be identified to 1) to determine effects on job satisfaction and retention, 2) minimize decreases in the quality of patient care and 3)determine impact on readiness.

Further research should include questionnaires specifically worded for nurse managers to clarify their perceptions of staff nurses' autonomy and authority. The study should include a larger sample size and include nurses who are in deployed environments at the time of the study.

Limitations and Recommendations

Numerous limitations were identified. First, the generalizability of the data is limited due to use of a convenience sample of active duty Army Nurse Corps officers. Direct extrapolation of the results of this study to other nursing groups is not possible due to the uniqueness of the practice culture/setting and job requirements of the military nurse. Due to difficulties initiating IRB approval at other

facilities and time constraints, the data collection was limited to one facility with approximately 200 nurses meeting the inclusion criteria. This precluded collection of data from nurses currently deployed. A larger sample may show greater significance with multiple variables affecting perceptions of authority and autonomy. Generalization is limited, therefore, to this specific group of military nurses.

Second, the facility at which the data were collected, conducts numerous research studies, and had in fact, distributed a staff satisfaction survey approximately one week prior to distribution of the questionnaires for this study. Many participants reported being overwhelmed with "surveys". Additionally, the facility was a large medical center with multiple layers of management. Future studies should include smaller military treatment facilities and clinics.

Although the survey did not appear to be a limitation, the number of questions, combined with the use of Likert-type scales, may have been an obstacle. Although only one questionnaire had missing items, several questionnaires were answered by choosing the same number on the scale for each question. The use of questionnaires designed specifically for nurse managers should be implemented to discern their perceptions of both their own autonomy and that of their staff nurses.

Additional recommendations involve clarification of demographics and distribution of the questionnaires. The demographic question concerning number of deployments needs to be clarified. Deployments should be more clearly defined concerning nature of deployment (field training exercise versus wartime) and length of deployment. For example, several respondents considered three-day field training exercises to AP Hill as deployments. Inability to receive IRB approval for a computerized Internet version of the questionnaire was also a limitation. This had the potential to increase return rate and provide a larger sample group, to include nurses currently deployed.

Summary

The military nurses in this sample group had perceptions of authority and autonomy just above midpoint of the measuring tool. Without a means of comparison, these perceptions appear low at approximately the sixty-fifth percentile. These perceptions were not significantly influenced by deployment experience, position or work environment. This sample group is, however, a small representation of Army Nurse Corps officers. This study should be repeated to include all active duty Army nurses. This would allow for generalization of the data and exploration of influences on perceptions of authority and

autonomy. The resulting information could effect strategies for ensuring not only readiness but also retention.

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APPENDICES

APPENDIX 1: IRB Approval USUHS

APPENDIX 2: IRB Approval Walter Reed Army Medical Center

APPENDIX 3: Permission for Nursing Authority/Autonomy Questionnaire

APPENDIX 4: Cover Letter

APPENDIX 5: Letter of Explanation

APPENDIX 6: Demographics Questionnaire

APPENDIX 7: Nursing Authority and Autonomy Questionnaire: Authority and Autonomy in Nursing Practice

APPENDIX 8: Nursing Authority and Autonomy Questionnaire: Importance of Practice

APPENDIX 9: Needs Satisfaction Questionnaire

APPENDIX 1

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
4301 JONES BRIDGE ROAD BETHESDA, MARYLAND 20814-4799

August 22, 2001

MEMORANDUM FOR CPT DENISE M. LYONS, GRADUATE SCHOOL OF NURSING

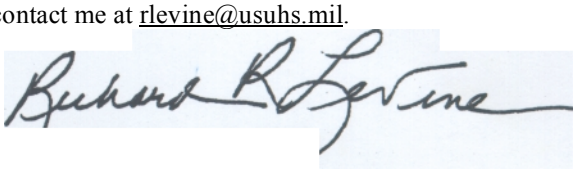
SUBJECT: IRB Approval of Protocol T061CI-01 as Exempt Human Research

Your research protocol entitled ***"Military Nurses Perceptions of Autonomy in Fixed versus Deployed Facilities: Implications for Readiness"*** was reviewed and approved for execution on 8/22/2001 as an **exempt** human research study under the provisions of 32 CFR 219.101(b)(3). This approval will be reported to the full IRB scheduled to meet on 13 September 2001.

The purpose of this study is to assess the effects of the restructuring of the military health care system on the current perceptions of autonomy held by military nurses in fixed and deployed facilities. The IRB understands that up to 240 Army nurses at four planned fled facilities (WR.AMC, Bayne-Jones ,ACH, WAMC, Darnell Community Hospital), as well as from the 28`h CSH, will be invited to participate in the study and that two questionnaires - the Nursing Authority and Autonomy Scale and the Needs Satisfaction Questionnaire - will be employed, along with a demographic questionnaire and two self-report items on morale. The IRB understands further that the questionnaires will be offered both in hard copy, via distribution by the head nurse, and on the internet, that you are offering a cover memo describing the study and -inviting anonymous participation, that no personal identifiers will be collected, and that volunteer identity, even via internet response, will not be known to you.

Because this is a USUHS-sponsored study, you are required to provide this office with approved protocols, consent forms, and IRB approval memos from each site/unit where/with whom you conduct your study.

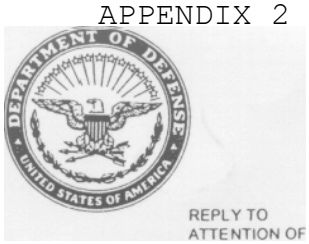
Please notify this office of any amendments you wish to propose and of any untoward incidents that may occur in the conduct of this project. If you have any questions regarding human volunteers, please call me at 301-295-3303 or contact me at rlevine@usuhs.mil.



Richard R. Levine,
Ph.D LTC, MS, USA
Director, Research Programs and
Executive Secretary, IRB

cc: Director, Research Administration

APPENDIX 2



DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
WALTER REED HEALTH CARE SYSTEM
WASHINGTON, DC 20307-5001

31 January 2002

MCHL-CI

MEMORANDUM FOR Janice B. Agazio, DNSc, Department of Nursing Research
Graduate School of Nursing
Uniformed Services University of the Health Sciences
Bethesda, Maryland 20814-4799

SUBJECT: Proposed Clinical Investigation Research Protocol - Exempt from Review

1. Your protocol entitled "Military Nurses' Perceptions of Autonomy_in Fixed Facilities: Implications for Readiness" was received in this department on 13 December 2001 and required clarifications were received on 29 January2002. This protocol has been reviewed by
LTC Raul Marin, MC, Asst Chief, Department of Clinical Investigation, Edward E. Bartlett, Ph.D., IRB Administrator, Department of Clinical Investigation, and the undersigned.

2. Per consensus of the Human Use Committee (HUC) at the 27 October 1998 HUC meeting and per Army Regulation 40-38, Clinical Investigation Program, Appendix B, paragraph B-5, Public Behavior and WRAMC Regulation 70-1, Clinical Investigation Program, WRAMC Research Activities, the research outlined in the proposed protocol meets the criteria to be exempted from further review by the WRAMC Clinical Investigation Committee and/or Human Use Committee.

3. Your research protocol has been assigned Work Unit #**02-75013E**. It will be reported as exempt to the Human Use Committee (HUC) on 12 February 2002. You may begin the study upon receipt of this letter for the distribution of 2 anonymous surveys, the Nursing Authority and Autonomy Scale (NAAS) and the Needs Satisfaction Questionnaire, to Army nurses at Walter Reed Army Medical Center.

4. No funding was requested from DCI. **Per exempt guidelines no other resources, such as supplies or statistical and computer support, are available**.

5. We would like to remind all investigators that a publication clearance is required for all written materials (i.e. manuscript or abstract) being submitted for publication /presentation.

6. If you have any questions, the POC is Vicki Miskovsky at (202) 782-7833.

Audrey S. Chang

AUDREY S. CHANG. Ph.D., DAC
Chief, Research Review Service
Co-Chairperson, Human Use Committee

cf. Chief, Research Administration Service

APPENDIX 3

_~ 03/27/2001 __20:35 708448222

Kathleen Blanchfield, PhD, RN
14327 S. Highland Ave.
Orland Park, Illinois 60462

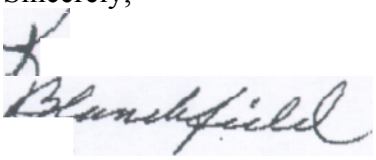
Dear Denise Lyons: March ~7, 2001

You have my permission to use the survey I developed on Perceptions of Nursing Authority and Autonomy. I developed this survey with permission to build from two previous surveys. One was by Stamps and Piedmonte on Nursing Autonomy and the other was by Katzman on Nursing Authority. Please note on the survey that is was developed by Kathleen Blanchfield with permission to build from the previous author's (state authors) surveys. You can obtain my dissertation from dissertation abstracts. The tile is Authority and Autonomy of Staff Nurses Providing Patient Care: A Study of Nursing Power, by Kathleen Blanchfield, 1992

I do believe including survey questions to address nurses' perceptions of accountability would enhance your study. In light of the challenges we all face in health care, authority and autonomy need to be grounded in accountability.

It was a privilege to talk to you. I wish you well and I look forward to receiving your findings.

Sincerely,



Kathleen Blanchf eld PhD, RN

APPENDIX 4

Cover Letter

Dear Army Nurse,

I am an active duty Army Captain attending the Uniformed Services University of the Health Sciences in the Family Nurse Practitioner (FNP) program. I am in the process of gathering data for my thesis titled "Military Nurses' Perceptions of Autonomy."

You are being invited to participate in this study by completing the attached questionnaires concerning your perceptions of your autonomy/authority in your practice and your work environment. The questionnaire takes approximately 15 minutes to complete.

The information provided by you and your colleagues will be confidential, and will be used to assist in medical readiness preparation and training of future military nurses. Therefore, you may choose to complete all of the questions or not answer questions with which you are not comfortable.

The Institutional Review Board at USUHS and your facility has approved this questionnaire. If you have any questions, comments or opinions on improvements to the questionnaire, please add them on to the questionnaire.

Please use the addressed, stamped envelope that has been provided and mail within 2 weeks of receipt. Your time will be greatly appreciated.

Sincerely,

DENISE M. LYONS
CPT, AN
FNP Student, USUHS, Bethesda, MD
HP: (410)674-3778
DP: (301)295-1001

APPENDIX 5

Research Study on Military Nurses' Perceptions of Autonomy

Introduction

You are being asked to participate in a research study that is seeking information on military nurses perceptions of their autonomy in practice. This briefing will provide you with information about the study, possible risks and benefits of participation, and confidentiality for participants. Your decision to participate in this study is voluntary and you may withdraw from the study at any time in the process.

Description of the Study

The department of Nursing Research, and Family Nurse Practitioner in the Graduate School of Nursing at the Uniformed Services University of the Health Sciences and CPT Denise M. Lyons are conducting a research study to describe the perceptions of military nurses regarding autonomy of practice and implications for readiness. There will be at least 200 participants in the study, and each will answer items in a questionnaire regarding perceptions of autonomy, work environment and demographic data. The questionnaire takes approximately 15 minutes to complete, and the data will be evaluated based on participants' responses.

Risks and Benefits

As a participant you will not receive any monetary compensation. There are no risks associated with participation and no direct benefits.

Privacy and Confidentiality

There is no identifying information on the questionnaire thus assuring confidentiality for participants. The participants will be returning the completed questionnaires in sealed envelopes, to be opened only by the researcher. Or participants may complete questionnaires on-line using randomly distributed User ID access codes. The questionnaires will be coded by number only, as well as, data compiled from the questionnaire. The results from data collection will be submitted to the Graduate School of Nursing, Uniformed Services University of the Health Sciences, as a written thesis/paper for publication. Interpreted data will be submitted to the author of the data collection tool as part of the agreement between the researcher and the author of the tool. The study may be replicated in the future in the Army or in any of the other uniformed services.

APPENDIX 6

NURSING AUTHORITY AND AUTONOMY QUESTIONNAIRE

In this section of the questionnaire, you are asked to provide information regarding your professional background. Please be sure to complete all the questions. Remember confidentiality will be maintained at all times.

Please circle the appropriate response to each item.

1. Age
   1 19-29
   2 30-39
   3 40-49
   4 50-59
   5 60 and over

2. Sex
   1 FEMALE
   2 MALE

3. First Nursing Preparation
   1 Diploma
   2 Associate degree
   3 Baccalaureate degree

4. Highest Education obtained
   1 Baccalaureate degree
   2 Masters degree in _____
   3 Doctorate in

5. Check your present position
   1 staff nurse _____
   2 charge nurse _____
   3 assistant nurse manager _____
   4 nurse manager _____
   5 advanced practice nurse _____
   List type of (APN)

6. Fill in number of years experience you have as a registered nurse _____

7. Length of time in your Current position
   1 0-1 year
   2 2-5 years
   3 6-10 years

8. Shift worked most often
   1 Day permanent
   2 Day rotating
   3 Evenings
   4 Nights

9. Type of unit you currently work on _____
(med-surg, peds, O.B., etc.)

10. Are you certified in your specialty area?
   1 Yes
   2 No

11. List type of units you have previously worked on:
_____
_____
_____
_____

12. How many times have you deployed? _____
Locations: _____
_____
_____
_____

13. Did you feel prepared for deployment?
   1 Yes
   2 No

14. What was your duty position while deployed? Fill in unit
   1 staff nurse _____
   2 charge nurse _____
   3 head nurse _____
   4 Other _____

15. What could have been done to better prepare you?

APPENDIX 7

NURSING AUTHORITY AND AUTONOMY QUESTIONNAIRE
STAFF NURSES

AUTHORITY AND AUTONOMY IN NURSING PRACTICE QUESTIONNAIRE

This questionnaire is divided into three sections: Section A asks questions about your perceptions of your actual nursing practice. Section B has questions about the importance of particular aspects of nursing practice and the last section asks for information about yourself in order to understand your responses in the first two sections. Please respond to each question by circling your answers.

Section A: Circle the response that most closely agrees with your views. Answer all statements; don't leave blanks. Rate your agreement or disagreement with each statement using a scale of 5 to 1.

Response Statements:

5 being strongly agree 1 being strongly disagree 0 being not applicable	Strongly Agree				Strongly Disagree	N/A
I. I plan the nursing care given to patients on my shift.	5	4	3	2	1	0
2. I assess patient responses to actual or potential health problems.	5	4	3	2	1	0
3. I change my patient's clinically inappropriate diet.	5	4	3	2	1	0
4. I can decide not to bathe my patient if conditions counter-indicate a bath in my judgement.	5	4	3	2	1	0
5. I am sometimes required to do things (on my job) that are against my better professional nursing judgement.	5	4	3	2	1	0
6. I initiate physical assessments of my patients.	5	4	3	2	1	0
7. I decide what to teach patients and family members about how to prevent illness.	5	4	3	2	1	0
8. I evaluate patient's responses to medication and treatment regimens prescribed by their physicians.	5	4	3	2	1	0

Response Statements:

5 being strongly agree 1 being strongly disagree 0 being not applicable (N/A)	Strongly Agree				Strongly Disagree	N/A
9. My nursing role is primarily as an assistant to the physician.	5	4	3	2	1	0
10. I understand the goals of my unit.	5	4	3	2	1	0
11. I can modify medications, including dosage and method of administration, when indicated by patients conditions.	5	4	3	2	1	0
12. I make decisions about pain management for my patients.	5	4	3	2	1	0
13. I can initiate interactions with other departments to coordinate the care given to my patients	5	4	3	2	1	0
14. I have the freedom in my work to make important decisions as I see fit and can count on my manager (supervisor/head nurse) to back me up.	5	4	3	2	1	0
15. I do many nursing care services for patients that are not under a physician's directions.	5	4	3	2	1	0
16. I have too much responsibility and not enough authority.	5	4	3	2	1	0
17. I initiate teaching patients how to care for themselves while recovering from illness or surgery.	5	4	3	2	1	0
18. I teach patients how to cope with chronic illness.	5	4	3	2	1	0
19. I manage equipment and supplies for effective delivery of care to my patients.	5	4	3	2	1	0
20. I decide on how often to take patient's blood pressure and temperature.	5	4	3	2	1	0
21. I feel that I am supervised more closely than is necessary.	5	4	3	2	1	0

Response Statements:

5 being strongly agree 1 being stongly disagree 0 being not applicable (N/A)	Strongly Agree				Strongly Disagree	N/A
22. A great deal of independence is permitted if not required of me.	5	4	3	2	1	0
23. I question physicians who prescribe inaccurate medications.	5	4	3	2	1	0
24. I am sometimes frustrated because all of my activities seem programmed for me.	5	4	3	2	1	0
25. I initiate discharge planning for my patients.	5	4	3	2	1	0
26. I am accountable for evaluating the nursing care given to my patients.	5	4	3	2	1	0
27. I feel I have sufficient input into the plan of care for each of my patients.	5	4	3	2	1	0
28. On my unit, a nurse manager makes all the decisions. I have little direct control over my own work.	5	4	3	2	1	0

Developed by Kathleen Blanchfield with permission from Stamps and Piedmonte (Nursing Autonomy) and Katzman (Nursing Authority) surveys

APPENDIX 8

NURSING AUTHORITY AND AUTONOMY QUESTIONNAIRE

STAFF NURSES

IMPORTANCE OF NURSING PRACTICE

SECTION B:

Please answer each item. In your judgment, circle the response that most closely indicates how important the following statements are for you. Rate the importance of each statement using a scale from 5 to 1.

Response Statements:

5 being very important 1 being not important 0 being not applicable (N/A)	Very Important				Not Very Important	N/A

How important is this statement for you:

1. Nurses assess their patients' conditions and their responses to actual or potential health problems.	5	4	3	2	1	0
2. Nurses plan the nursing care they give to their patients on their shift.	5	4	3	2	1	0
3. Nurses decide what to teach patients and their significant others about illness and care.	5	4	3	2	1	0
4. Nurses evaluate their patients' responses to their nursing care and therapeutic regimen.	5	4	3	2	1	0
5. Nurses have a great deal of independence in their work.	5	4	3	2	1	0
6. Nurses have complete accountability for their patients.	5	4	3	2	1	0
7. Nurses have sufficient input into how their care is evaluated.	5	4	3	2	1	0
8. Nurses have a great deal of control over how they actually deliver care to their patients.	5	4	3	2	1	0
9. How important to staff nurses is autonomy in their nursing practice?	5	4	3	2	1	0
10. How important to staff nurses is nursing authority to deliver patient care?	5	4	3	2	1	0

APPENDIX 9

Needs Satisfaction Questionnaire

Please answer each item. In your judgment, circle the response that most closely indicates the current status and how you perceive "it should be" for each statement.

Rate the importance of each statement using a scale from 7 to 1, with 7 being maximum and 1 being minimum.

(max) 7 6 5 4 3 2 1 (min)

1. The opportunity, in my position, to give help to other people

   How much is there now?

   (max) 7 6 5 4 3 2 1 (min)

   How much should there be?

   (max) 7 6 5 4 3 2 1 (min)

2. The opportunity to develop friendships/mentorships in my position.

   How much is there now?

   (max) 7 6 5 4 3 2 1 (min)

   How much should there be?

   (max) 7 6 5 4 3 2 1 (min)

3. The feeling of self-esteem a person gets from being in my position

   How much is there now?

   (max) 7 6 5 4 3 2 1 (min)

   How much should there be?

   (max) 7 6 5 4 3 2 1 (min)

4. The prestige of my position in the unit (that is, received from others in the unit)

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

5. The authority connected with my position

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

6. The opportunity for independent thought and action in my position

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

7. The opportunity, in my position, for participation in setting of unit goals

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

8. The opportunity, in my position, for participation in the

determination of methods and procedures used on unit

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

9. The opportunity for personal growth and development in my position

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

10. The feeling of self-fulfillment a person gets being in my position (that is, feeling of being able to use one's own unique capabilities, realizing one's potential)

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

11. The feeling of worthwhile accomplishment in my position

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

12. The feeling of security in my position

How much is there now?

(max) 7 6 5 4 3 2 1 (min)

How much should there be?

(max) 7 6 5 4 3 2 1 (min)

Porter, L. (1962). Job attitudes in management: Perceived deficiencies in need fulfillment as a function of job level. Journal of Applied Psychology, 46, 375-384.